STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DINC	00	COMPL	ETED
		15G553	A. BUII			01/28/	2013
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODTUMEST IND	IANIA INC. THE			TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		WERKIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0000							
	This visit was fo	or the investigation of	W0	000			
	Complaint #IN0	0122535.					
	•						
	COMPLAINT #	IN00122535·					
		ederal/State deficiencies					
	-						
		egation are cited at					
		7210, W318, W331, and					
	W436.						
	Unrelated defici	ency cited.					
	Dates of Survey	r: January 22, 23, 24, 25,					
	_	. January 22, 23, 24, 23,					
	and 28, 2013.						
	Facility number:	001067					
	Provider number	r: 15G553					
	AIM number: 1	00245460					
	Surveyors:						
	_	dical Cumpayan III Taana					
	-	dical Surveyor III-Team					
	· ·	through 1/28/13)					
		edical Surveyor III					
	(1/22/13 through	1/25/13)					
	Janet Adams, Pu	ıblic Health Nurse					
	Surveyor III (1/2						
	1/2	-· - /					
	The following for	daral dafiajanajas alsa					
	_	ederal deficiencies also					
		ings in accordance with					
	460 IAC 9.						
	Quality Review	completed 2/4/13 by Ruth					
	Shackelford, Me	edical Surveyor III.					
		-					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

001067

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM - 01/2	TE SURVEY PLETED 28/2013			
ARC OF	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K11

Fac

Facility ID: 001067

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G553	B. WIN			01/28/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF I	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0186	483.430(d)(1-2) DIRECT CARE S The facility must period for care staff to mana accordance with the plans. Direct care staff and on-duty staff calcular staff calcular staff calcular staff and on record facility failed to numbers to trans and sampled clients. Findings include The facility's recultarial staff and calcular staff and calcular staff and calcular staff. 1. "Date: 12/01/Narrative: Staff A] when she slid then complained Nurse was inform Coordinator that complaining of control staff (client A) transposition of control staff (client A) transposition and control staff (provide sufficient direct age and supervise clients in their individual program are defined as the present ulated over all shifts in a reach defined residential review and interview, the provide sufficient staff fer without injury for 1 of s (client A). cords were reviewed on A.M The review lowing incidents A: //2012, Name: [client A], were transferring [client I down to the floor and that her chest hurt. med by the Service	W0	TAG	The Service Coordinator and Area Manager will ensure that house is staffed to the requirement. To ensure future compliance, an automated system has been put in place notify the Area Manager if staf not clock in within 15 minutes the beginning of their shift.	to f do	DATE 02/19/2013
		and labs (laboratory					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 01/28/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
	(computerized so and abdomen can Consult with sur came back negat scheduled for dis 12/12/12. All m previously order home with an ord (physical therapy The therapist has next week. She workshop and al "Date of inciden [Client A], What client [client A] staff #3) noticed a new bruise on report and notified by you think cour reoccurrence of Lead Supervisor adequate staff the [client A] proper lift (lifting device implemented as Further review or report indicated (Licensed Practical A) was refusing evening of the 25 staff attempted to	ormal. A CAT scan can) of the head, chest me back normal also. geon for spinal stenosis ive so [client A] is scharge on Wednesday, edications remain as ed. She [client A] came der for outpatient PT/OT //occupational therapy). s sent her evaluation for (client A) has returned to I previous activities." t: 12/31/12, Client: c happened: Upon giving a bed bath, I (direct care a scrape on her knee and ther arm. Did incident ed nurse. What measures ald have prevented this Incident/Accident?" #1 indicated: "Have at is able to transport thy or the use of a hoyer e) should be soon as possible." f the 12/31/12 incident action taken by LPN cal Nurse) #1: "[Client staff assistance on the 8th (12/28/12). When to transfer her she fought the floor. No injury						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN	G		01/28/2	013
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1921 54	TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		at but staff called for					
	assistance to get	her (client A) off the					
	floor. She (client A) sustained the bruise						
	and scratch whil	e getting her up and into					
	bed."						
	"Date: 01/08/20	13, Name: [client A],					
	Narrative: Rece	ived phone call from					
	group home staf	f approximately 9:00pm					
	stating that [clien	nt A] had slid herself					
	down, with staff	assistance, to the floor.					
		s in her behavior plan}.					
	`	istance to get her up since					
		ble to assist. Instructed					
		manager to send					
		over to help. Received a					
		taff stating that [client A]					
		athing and 911 had been					
		Resolve: Second staff					
	started CPR (Car						
		nd continued until medics					
	,	over. [Client A] was					
		ospital] and intubated					
	_	olaced). She remains on					
	life support at th	,					
	ine support at til	is time.					
	Client A's record	l was reviewed on					
		P.M A review of the					
		avior management plan					
	failed to indicate	-					
		ior of sliding down to					
		red position. A 11/27/12					
		assessment indicated the					
	client was, "Very	y tired and lethargic.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN	G		01/28/2	013
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		elf or help transfer."					
	Review of a hospital discharge summary, dated 12/12/12, included a Rehab						
	` ′	Evaluation which					
		A had a Rehab Diagnoses					
		ill (sic) with chest pain,					
		pance with General					
		eview of client A's "Fall					
		d 11/12, indicated					
	-	a wheelchair and a gait					
	belt to ambulate.	."					
	Client A's record	ds were further reviewed					
		:07 A.M Review of					
		al records indicated the					
		ars of age at the time of					
	· ·	d a history of recent					
		for chest pain and					
	_	failure. Review of the					
	client's hospital						
	_	in November, 2012,					
	_	and January, 2103					
		A had a history of chronic					
		disease. Review of the					
		1/10/13 hospital and					
		Is failed to indicate the					
		sfers of client A had					
		e client's 1/8/13 cardiac					
	arrest.	The second of th					
	Direct care staff	#1 was interviewed on					
		P.M Direct care staff #1					
		would not help with					
		ould often slide to the					
	u ansiers and Wo	uia often shae to the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPI	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		15G553	B. WING			01/28/	2013
NAME OF I	PROVIDER OR SUPPLIE	P	STR	EET A	ADDRESS, CITY, STATE, ZIP CODE		
					TH AVE W		
ARC OF	NORTHWEST INC	DIANA INC, THE	ME	RRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	ì	DEFICIENCY)		DATE
		g transferred due to her					
		he Tuesday that she went					
	_	oital (1/8/13), [Direct care					
	1 -	ransferred her to the toilet					
		chair. When she said she					
	1	ried to move her back to					
		but she slid down to the					
	floor and we co	uldn't get her back up.					
	_	ff #2] went and got some					
	sheets and we re	olled [client A] into the					
	sheets and carri	ed her to her bedroom.					
	We couldn't lift	her so [direct care staff					
	#2] called the ar	rea manager to get another					
	person over to t	he group home so we					
	could put her in	bed. [Direct care staff					
	#2] doesn't usua	ally work this group home					
	and she is a sma	all person so her and I					
	could not lift he	r (client A) by ourselves."					
	Direct care staff	f #2 was interviewed on					
	1/23/13 at 9:55	A.M Direct care staff #2					
	stated, "We (dir	ect care staff #1 and #2)					
	were unable to t	ransfer [client A] from the					
	toilet back to he	er wheelchair on that					
	Tuesday night (1/8/13). We lowered her					
	to the floor and	then I went and got some					
		olled her (client A) into					
		arried her to her room. I					
	then went and c	alled the area manager so					
		someone over to help us					
		a) back into bed.					
	Service Coordin	nator #1 was interviewed					
		0:37 A.M Service					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G553	B. WIN			01/28/2013	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIO TUE			TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIO DATE	Ν
TAG		R LSC IDENTIFYING INFORMATION)		TAG	Dirichi.e.i,	DATE	
		stated, "Sliding out of her					
	(client A's) whee						
	`	2) and it occurred on three					
	· ·	mber 1st (2012),					
		(2012), and January 8th					
	` ′	he slides to the floor it					
	takes a good thre	ee people to pick her up."					
	Staffing records	for December 2012 and					
		ere reviewed on 1/23/13 at					
		view of staffing numbers					
		me for December 1st,					
		wo staff were on duty					
		id from her wheelchair					
		. On December 31st,					
	_	were on duty when client					
		wheel chair during a					
		nuary 8th, 2013, 2 staff					
		nen client A slid to the					
	1						
	floor during a tra	alisivi.					
	This federal rela	tes to complaint					
	#IN00122535.						
	9-3-3(a)						
	(u)						

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Event ID: RR5K11

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/28/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET . 1921 54	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review and interview, the facility failed to train direct care staff on appropriate transfer methods for 1 of 3 sampled clients (client A). Findings include: The facility's records were reviewed on 1/22/13 at 11:34 A.M The review indicated the following incidents involving client A: "Date: 12/01/2012, Name: [client A], Narrative: Staff were transferring [client A] when she slid down to the floor and then complained that her chest hurt. Nurse was informed by the Service Coordinator that [client A] was complaining of chest pain and that she {service coordinator} had advised the group home staff to call 911 and have her (client A) transported to [local hospital] for evaluation and treatment. [Client A] was admitted to the hospital. Vitals, O2 (oxygen) levels, and labs (laboratory tests) were all normal. A CAT scan (computerized scan) of the head, chest and abdomen came back normal also. Consult with surgeon for spinal stenosis	W0192	All staff working at this facility be trained on the following: Transferring and transporting client safely, behavior plans wapplicable, medical signs and symptoms, and reporting changes in client condition.	

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/28	ETED
	PROVIDER OR SUPPLIER			STREET A 1921 54	DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	came back negates scheduled for dis 12/12/12. All me previously order home with an ore (physical therapy. The therapist has next week. She workshop and al "Date of incident [Client A], What client [client A] staff #3) noticed a new bruise on report and notified on you think coure occurrence of the Lead Supervisor adequate staff the [client A] proper lift (lifting devicting limplemented as Further review or report indicated (Licensed Practical A) was refusing evening of the 25 staff attempted to occurred from the assistance to get floor. She (client A) evening the content of the conten	ive so [client A] is scharge on Wednesday, edications remain as ed. She [client A] came der for outpatient PT/OT p/occupational therapy). It is sent her evaluation for (client A) has returned to all previous activities." It: 12/31/12, Client: happened: Upon giving a bed bath, I (direct care a scrape on her knee and ther arm. Did incident ed nurse. What measures all have prevented this Incident/Accident?" #1 indicated: "Have at is able to transport thy or the use of a hoyer					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		(X2) MULTIF A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE COMPL 01/28/	ETED	
	PROVIDER OR SUPPLIER		STF 19	21 54 ⁻	DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Narrative: Rece group home staff stating that [client down, with staff {This behavior is Staff needed assi [client A] is unal staff to call area additional staff of second call for sichad stopped brea called. Plan to Be started CPR (Car Resuscitation) and arrived and took taken to [local horoid (breathing tube plife support at the Client A's record 1/22/13 at 12:01 client's 1/12 behave failed to indicate addressed behave floor from a seat facility nursing a client was, "Very Won't feed herse Review of a hosy dated 12/12/12, in	ever to help. Received a taff stating that [client A] athing and 911 had been desolve: Second staff redio-Pulmonary and continued until medics over. [Client A] was espital] and intubated placed). She remains on its time." Is were reviewed on P.M A review of the avior management plan					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN			01/28/	2013
NAME OF I	PROVIDER OR SUPPLIER)	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NOVIDER OR SUPPLIER			1921 54	TH AVE W		
	NORTHWEST IND				LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		A had Rehab Diagnoses					
		but were not limited to:					
	"Frequent fall with chest pain, and, Gait disturbance with General weakness." Client A's records were further reviewed on 1/23/13 at 10:07 A.M Review of						
		al records indicated the					
		ars of age at the time of					
		d a history of recent					
		for chest pain and					
	_	failure. Review of the					
	_						
	client's hospital						
	_	in November, 2012,					
	· ·	and January, 2103					
		A had a history of chronic					
		disease. Review of the					
	client's 1/8/13 to	1/10/13 hospital and					
	physician record	ls failed to indicate the					
	group home tran	sfers of client A had					
	contributed to th	e client's 1/8/13 cardiac					
	arrest.						
	Direct care staff	#1 was interviewed on					
		P.M. Direct care staff #1					
		would not help with					
		ould often slide to the					
	· ·	g transferred due to her					
	weakness." Who	en asked if she had been					
	trained on transf	Fers, direct care staff #2					
	stated, "No."						
	Direct care staff	#2 was interviewed on					
		A.M When asked if she					
	1143113 at 3.33 I	1vi vviicii askeu ii siic					

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	OF CORRECTION OF CORRECTION 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 01/	TE SURVEY MPLETED 28/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	had been trained on transfers, direct care staff #2 stated, "Yes, when I first started work here."						
	Direct care staff #1's training records were reviewed on 1/24/13 at 12:34 P.M A review of direct care staff #1's training records indicated she had not received training in techniques in transferring individuals. Direct care staff #2's training records were reviewed on 1/24/13 at 12:37 P.M A review of direct care staff #2's training records indicated she had last been trained on transferring individuals on 7/31/2006. This federal relates to complaint #IN00122535. 9-3-3(a)						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553			LDING	00	(X3) DATE : COMPL 01/28/	ETED	
	PROVIDER OR SUPPLIER			1921 54	ADDRESS, CITY, STATE, ZIP CODE ITH AVE W LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0210	interdisciplinary to assessments or respectively to supplement the conducted prior to Based on record facility failed to of 1 of 3 sampled. Findings include The facility's recently at 11:34 indicated the following client. "Date: 12/01/20 Narrative: Staff A] when she slid then complained Nurse was inform Coordinator that complaining of complaining	ter admission, the eam must perform accurate eassessments as needed e preliminary evaluation o admission. review and interview, the assess the transfer needs d clients (client A). : ords were reviewed on A.M The review lowing incidents A: 12, Name: [client A], were transferring [client d down to the floor and that her chest hurt. med by the Service	W0	210	On December 17, 2012 a tear meeting was held to discuss of current condition and potential changes to her programming a medical treatment. CL A repeat falls were discussed and since the team saw this as a symptor of her current medical condition the team chose to follow a medical rout of treatment rather than label it as a behavior. Whoever stated that sliding on her chair was in her behavior was in error. Rather the team made appointments for CL A to be evaluated by a physical therapist on December 4, 201 and January 9, 2013 to see if strength training exercises or adaptive equipment would be appropriate for her case. Despone instance of her sliding out her chair following this team meeting the direction of care maintained. 2/25/13 To ensure future compliance a changes in client condition will evaluated by the team or the appropriate professional base on the presenting change with days of knowledge.	CL A and and ated e om on on o 2 bite of	02/19/2013

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN	G		01/28/2	2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODEL WEST IND	IANIA INIC. TUE			TH AVE W		
	NORTHWEST IND				LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		tive so [client A] is		0			BILLE
	scheduled for discharge on Wednesday,						
	12/12/12. All medications remain as						
		red. She [client A] came					
		der for outpatient PT/OT					
		y/occupational therapy).					
		s sent her evaluation for					
		(client A) has returned to					
		Il previous activities."					
	Client A's record was reviewed on						
	1/22/13 at 12:03	P.M The review failed					
	to indicate the P	T/OT evaluation.					
	"Date of inciden	t: 12/31/12, Client:					
	[Client A], Wha	t happened: Upon giving					
	client [client A]	a bed bath, I (direct care					
	·	a scrape on her knee and					
		her arm. Did incident					
		ed nurse. What measures					
		ıld have prevented					
		this Incident/Accident?"					
	_	#1 indicated: "Have					
		at is able to transport					
		rly or the use of a hoyer					
	lift (lifting devic						
	_	soon as possible."					
		of the 12/31/12 incident					
		taken by LPN (Licensed					
		#1: "[Client A] was					
	_	sistance on the evening of					
	the 28th (12/28/	<i>'</i>					
	_	nsfer her she fought and					
	slid down to the	floor. No injury occurred					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G553	B. WIN	G		01/28/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITH AVE W		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ff called for assistance to					
		a) off the floor. She					
	(client A) sustain	ned the bruise and scratch					
	while getting her	up and into bed."					
	"Date: 01/08/20	13, Name: [client A],					
	Narrative: Rece	ived phone call from					
	group home staff	f approximately 9:00pm					
	stating that [clien	nt A] had slid herself					
	down, with staff	assistance, to the floor.					
	{This behavior is	s in her behavior plan}.					
	•	istance to get her up since					
		ole to assist. Instructed					
	staff to call area						
		over to help. Received a					
		taff stating that [client A]					
		thing and 911 had been					
	• •	Resolve: Second staff					
	started CPR (Car						
	· · · · · · · · · · · · · · · · · · ·	nd continued until medics					
		over. [Client A] was					
	=	ospital] and intubated					
	, c 1	placed). She remains on					
	life support at th	is time."					
	O1:	1 1					
		l was reviewed on					
		P.M A review of the					
		avior management plan					
	failed to indicate						
	addressed behav	ior of sliding down to					
	floor from a seat	ed position. A 11/27/12					
	facility nursing a	ssessment indicated the					
	client was, "Very	y tired and lethargic.					
	Won't feed herse	elf or help transfer.					

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Event ID: RR5K11

Facility ID: 001067

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN			01/28/	2013
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		·		TAG			DATE
		pital discharge summary,					
	dated 12/12/12, included a Rehab (rehabilitation) Evaluation which						
	indicated client A had Rehab Diagnoses						
	which included but were not limited to:						
	"Frequent fall with chest pain, and, Gait disturbance with General weakness." A						
	review of a 12/13/12 facility nursing assessment failed to assess client A's						
	diagnoses of frequent falls, gait						
	disturbance with general weakness and						
	failed to address the client's transfer						
	needs.						
	Client A's record	ds were further reviewed					
	on 1/23/13 at 10	:07 A.M Review of					
	client A's medic	al records indicated the					
	client was 83 ye	ars of age at the time of					
	her death and ha	d a history of recent					
	hospitalizations	for chest pain and					
	congestive heart	failure. Review of the					
	client's hospital	records from					
	_	in November, 2012,					
	-	and January, 2103					
		A had a history of chronic					
		disease. Review of the					
		1/10/13 hospital and					
		Is did not indicate the					
	1 0 1	sfers of client A had					
		e client's 1/8/13 cardiac					
	arrest.						
	Camping Carrellin	aton #1 mag intermisers d					
		ator #1 was interviewed					
	OII 1/23/13 at 10	:37 A.M Service					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		r í	DING	<u>00</u>	COMPL: 01/28/	ETED		
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORM	Y FULL F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	Coordinator #1 stated, "Sliding out o (client A's) wheelchair started in November (2012) and it occurred on occasions, December 1st (2012), December 31st (2012), and January 8 (2013)." LPN #1 was interviewed on 1/23/13 12:01 P.M When asked if client A's transfer needs had been assessed, LP stated, "No." This federal relates to complaint #IN00122535. 9-3-4(a)	three 8th at						

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Facility ID: 001067

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553 NAME OF PROVIDER OR SUPPLIER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410	ON
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W	ON
NAME OF PROVIDER OR SUPPLIER 1921 54TH AVE W	ON
	ON
ARC OF NORTHWEST INDIANA INC, THE	ON
	ON
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)	ON
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY: DATE	
W0318 483.460	
HEALTH CARE SERVICES The facility must ensure that specific health	
care services requirements are met.	
Based on record review and interview, the W0318 Please see W186; W192; W210, 02/19/20)13
Condition of Participation of Health Care and see W331.	
Services is not met as the facility failed to	
assure 1 of 3 sampled clients (Client A)	
received adequate health care	
assessments, monitoring and services.	
Findings include:	
1. Please refer to W186 as the facility	
failed to provide sufficient staff numbers	
to transfer without injury for 1 of 3	
sampled clients (client A).	
sampled elicitis (client A).	
2. Please refer to W192 as the facility	
failed to train direct care staff on	
appropriate transfer methods for 1 of 3	
sampled clients (client A).	
3. Please refer to W210 as the facility	
failed to assess the transfer needs of 1 of 3	
sampled clients (client A).	
4. Please refer to W331 as the facility	
failed to provide adequate nursing	
services: 1. To assess, implement,	
provide sufficient staff, and provide staff	
training in regards to a method of	
transferring 1 of 3 sampled clients (client	
A) without causing injury to the client, 2.	
To provide adequate health monitoring	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 28/2013
	PROVIDER OR SUPPLIER		192	EET ADDRESS, CITY, STATE, ZI 1 54TH AVE W RRILLVILLE, IN 46410	iP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO T	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	with client needs clients (client A) documentation for PRN (as needed) administration for (client A), and 4 medications per 3 sampled clients. 5. Please refer to failed to assure 1 (client A) utilize	physician's orders for 1 of				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DIVIDING 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	15G553	A. BUII			01/28/	
		100000	B. WIN			01/20/	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W		
ARC OF	NORTHWEST INDI	ANA INC, THE			ILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0331	483.460(c) NURSING SERV The facility must provide services in according facility failed to services: 1. To a provide sufficient training in regard transferring 1 of A) without causing To provide adequates and blood with client needs clients (client A) documentation for PRN (as needed) administration for (client A), and 4 medications per provide adequates as ampled clients. Findings includes The facility's recent 1/22/13 at 11:34 indicated the following client. 1. "Date: 12/01/Narrative: Staff A] when she slid then complained	provide clients with nursing dance with their needs. review and interview, the provide adequate nursing assess, implement, at staff, and provide staff dis to a method of 3 sampled clients (client ang injury to the client, 2. the health monitoring pressure) in accordance as for 1 of 3 sampled adequate for the effectiveness of a medications after for 1 of 3 sampled clients. To administer physician's orders for 1 of s (client A). : ords were reviewed on A.M The review dowing incidents A: //2012, Name: [client A], were transferring [client and that her chest hurt. Included by the Service are reviewed by the Service and interview down to the floor and that her chest hurt.	W0:		Nursing services will be involved in developing systems for monitoring and training staff of the following: transferring and transporting client safely, medicings and symptoms, reporting changes in client condition, monitoring and document pulsimonitoring and document blood pressure, transferring medical orders, and documenting the of PRN medications. To ensure future compliance, new staff will be trained on the topics and all staff will be retrained annually. The Area Manager will ensure the staff training records are up to date	n lical g se, od tion use all ese	02/19/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI		
AND PLAN	OF CORRECTION	15G553		LDING	00	COMPL 01/28/	
		100000	B. WIN			01/28/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	complaining of c	chest pain and that she					
	{service coordinates	ator} had advised the					
	group home staff	f to call 911 and have her					
	(client A) transpo	orted to [local hospital]					
	for evaluation an	nd treatment. [Client A]					
	was admitted to	the hospital. Vitals, O2					
	(oxygen) levels,	and labs (laboratory					
		ormal. A CAT scan					
	(computerized so	can) of the head, chest					
	and abdomen car	me back normal also.					
Consult with surgeon for spinal stenosis							
came back negative so [client A] is							
	scheduled for dis	scharge on Wednesday,					
	12/12/12. All m	edications remain as					
	previously order	ed. She [client A] came					
	home with an ord	der for outpatient PT/OT					
	(physical therapy	y/occupational therapy).					
	The therapist has	s sent her evaluation for					
	next week. She	(client A) has returned to					
	workshop and all	l previous activities."					
	"Data of incident	t: 12/31/12, Client:					
		t happened: Upon giving					
		a bed bath, I (direct care					
		a scrape on her knee and					
	· ·	her arm. Did incident					
		ed nurse. What measures					
	*	ald have prevented					
	reoccurrence (sic	_					
		nt?" Lead Supervisor #1					
		adequate staff that is					
		[client A] properly or the					
	•	ft (lifting device) should					
		as soon as possible."					
	oc implemented	as soon as possible.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G553	B. WIN	G		01/28/2013	
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG	1	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		of the 12/31/12 incident					
	indicated action taken by LPN (Licensed						
		#1: "[Client A] was					
	1	sistance on the evening of					
	the 28th (12/28/	· ·					
	_	nsfer her she fought and					
		floor. No injury occurred					
		ff called for assistance to					
		a) off the floor. She					
	` ′	ned the bruise and scratch					
	while getting her up and into bed."						
	"Date: 01/08/20	13, Name: [client A],					
	Narrative: Rece	ived phone call from					
	group home staf	f approximately 9:00pm					
	stating that [clie	nt A] had slid herself					
	down, with staff	assistance, to the floor.					
	{This behavior i	s in her behavior plan}.					
	Staff needed ass	istance to get her up since					
	[client A] is una	ble to assist. Instructed					
	staff to call area	manager to send					
	additional staff of	over to help. Received a					
	second call for s	taff stating that [client A]					
	had stopped brea	athing and 911 had been					
	called. Plan to F	Resolve: Second staff					
	started CPR (Ca	rdio-Pulmonary					
	,	nd continued until medics					
	1	over. [Client A] was					
		ospital] and intubated					
	=	placed). She remains on					
	life support at th	•					
	Client A's record	d was reviewed on					
	1/22/13 at 12:01	P.M A review of the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	LDING	NSTRUCTION 00	(X3) DATE COMPI 01/28	ETED
	PROVIDER OR SUPPLIER		STREET A 1921 54	DDRESS, CITY, STATE, ZIP CODE TH AVE W LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	failed to indicate addressed behave floor from a seat facility nursing a client was, "Very Won't feed herse Review of a host dated 12/12/12, (rehabilitation) Findicated client which included Is "Frequent fall we disturbance with review of a 12/1 assessment failed diagnoses of free disturbance with failed to address needs. A review Plan", dated 11/1 uses a wheelchait ambulate." Client A's record on 1/23/13 at 10 client A's medical client was 83 years and has hospitalizations congestive heart client's hospital and hospitalizations.	ior of sliding down to ed position. A 11/27/12 assessment indicated the y tired and lethargic. elf or help transfer." pital discharge summary, included a Rehab Evaluation which A had Rehab Diagnoses but were not limited to: ith chest pain, and, Gait General weakness." A 3/12 facility nursing d to assess client A's quent falls, gait general weakness and the client's transfer of client A's "Fall Risk 12, indicated "[Client A] ar and a gait belt to Is were further reviewed 107 A.M Review of al records indicated the ars of age at the time of d a history of recent for chest pain and failure. Review of the				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
11112 12111	or condition,	15G553		LDING		01/28/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER				ITH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFECT.)		DATE
		A had a history of chronic lisease. Review of the					
		1/10/13 hospital and					
	physician records did not indicate the group home transfers of client A had						
	contributed to the client's 1/8/13 cardiac						
	arrest.						
	uriost.						
	Direct care staff	#1 was interviewed on					
	1/22/13 at 5:45 I	P.M. Direct care staff #1					
stated client A "would not help with		would not help with					
	transfers and would often slide to the						
	floor when being transferred due to her						
	weakness." Who	en asked if client A had					
	any lift or gait be	elt to assist in transferring					
	her, direct care s	taff #1 stated, "There was					
	a hoyer lift that of	came that day (1/8/13) but					
	there were no pa	ds that came with it so					
	we couldn't use i	t and she (client A) didn't					
	have a gait belt t	hat I know of." Direct					
	care staff #1 furt	her stated, "We (direct					
	care staff working	ng at the group home)					
	1	sfer her but she was just					
	_	she got a bruise or a					
		om picking her up off of					
	_	ting her in her wheelchair					
		the Tuesday that she went					
	_	ital (1/8/13), [Direct care					
	_	ansferred her to the toilet					
		chair. When she said she					
		ied to move her back to					
		out she slid down to the					
		ıldn't get her back up.					
	[Direct care staff	f #2] went and got some					

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FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL 01/28/	
		15G553	B. WIN			01/28/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IIE.	DATE
	sheets and we ro	lled [client A] into the					
	sheets and carrie	d her to her bedroom.					
	We couldn't lift l	ner so [direct care staff					
	#2] called the are	ea manager to get another					
	person over to the group home so we						
	could put her in bed. [Direct care staff						
	#2] doesn't usual	ly work this group home					
	and she is a small	l person so her and I					
	could not lift her	(client A) by ourselves.					
As she was calling, I noticed [client A]		ng, I noticed [client A]					
looking like she was sleeping so I		was sleeping so I					
checked her and she was not breathing. I							
	yelled for [direct	care staff #2] to call 911					
	and I started CPI	R and continued until the					
	ambulance came	and they took over					
	(CPR)." When a	sked if she had been					
	trained on transf	ers, direct care staff #2					
	stated, "No."						
	Direct care staff	#2 was interviewed on					
	1/23/13 at 9:55 A	A.M Direct care staff #2					
	stated, "We (dire	ect care staff #1 and #2)					
	were unable to tr	ansfer [client A] from the					
	toilet back to her	wheelchair on that					
	Tuesday night (1	/8/13). We lowered her					
	to the floor and t	hen I went and got some					
	sheets and we ro	lled her (client A) into					
	the sheets and ca	rried her to her room. I					
	then went and ca	lled the area manager so					
	she would send s	someone over to help us					
) back into bed. [Direct					
		d [client A] wasn't					
	_	e immediately started					
	_	lance came and they took					
		-					

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Event ID: RR5K11

Facility ID: 001067

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 01/28 .	LETED
	PROVIDER OR SUPPLIER		p. wiii	STREET A 1921 54	ADDRESS, CITY, STATE, ZIP CODE STH AVE W LLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	a gait belt or any with transfers, di "No, no gait belt that was delivered that Tuesday (1/4 because the pads come with it did she had been traicare staff #2 stat started work here. Client A's record 1/23/13 at 10:07 A's medical record was 83 years of a death and had a land hospitalizations congestive heart client's hospitalizations. December, 2012 indicated client and acute heart of client's 1/8/13 to physician record group home trans	Is were reviewed on A.M Review of client rds indicated the client age at the time of her history of recent for chest pain and failure. Review of the					
	reviewed on 1/24 review of direct	#1's training records were 4/13 at 12:34 P.M A care staff #1's training d she had not received					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RR5K11

Facility ID: 001067

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN	G		01/28/	2013
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ITH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	iques in transferring					
	individuals.						
	D:						
		#2's training records were					
		4/13 at 12:37 P.M A					
	review of direct care staff #2's training records indicated she had last been trained						
	on transferring individuals on 7/31/2006.						
	Compies Commission	atan #1 xxxaa intai					
	Service Coordinator #1 was interviewed on 1/23/13 at 10:37 A.M Service Coordinator #1 stated, "Sliding out of her						
		_					
	(client A's) whee						
	,	2) and it occurred on three					
	occasions, Dece	* **					
		2012), and January 8th					
	` ′	he slides to the floor it					
	_	ee people to pick her up.					
	I -	initially ordered around					
		ecember (2012)." Service					
		further stated, "We didn't					
		e were waiting for a					
	1 * *	r to start using it. We					
		nally decide in January at					
	her (client A's) a	innual meeting."					
	Ctoff	for Documber 2012 - 1					
	_	for December 2012 and					
	1	ere reviewed on 1/23/13 at					
		view of staffing numbers					
		me for December 1st,					
		wo staff were on duty					
		id from her wheelchair					
	_	On December 31st,					
	2012, two staff v	were on duty when client					

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Event ID: RR5K11

Facility ID: 001067

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G553	B. WIN	G		01/28/2	2013
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
450.05	NORTH WATERT IND				TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		wheel chair during a					
		uary 8th, 2013, 2 staff					
	1	en client A slid to the					
	floor during a tra	ansfer.					
		erviewed on 1/23/13 at					
	12:01 P.M LPN #1 stated, "[Client A]						
		son transfers. No devices					
(hoyer lift) were being used. We were							
	talking about getting a hoyer lift but						
	hadn't gotten one. A two person transfer was rough because [client A] was no help.						
		n able to assist with					
		east the last couple of					
	months." When	asked if client A's					
	transfer needs ha	nd been assessed, LPN #1					
	stated, "No."						
	2 0 1/22/12	(1.20 DM					
		t 1:30 PM a record review					
		A's diagnoses included,					
		ited to, depression, right					
		rthritis, psychosis, mental					
		eardiovascular disease.					
		cation Administration					
	` ′	lated for December 2012					
	`	2) and January 2013					
	` /	were reviewed and					
		rere to take Client A's					
	blood pressure a	nd pulse twice daily.					
	The December ?	012 MAR, reviewed on					
		PM, indicated staff					
		ent A's blood pressure					
		oth of December 2012.					
	iwice in the mon	iui di Decembel 2012.					

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Facility ID: 001067

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G553	B. WING		01/28/2013
NAME OF F	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
				4TH AVE W	
ARC OF	NORTHWEST IND	IANA INC, THE	MERR	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ated staff did not			
		A's pulse in the month of			
	December 2012. The MAR indicated				
	_	esent in the facility home			
	· ·	mber and in the hospital			
	11 days.				
	The January 2013 MAR, reviewed on				
	1/23/13 at 1:38 PM, indicated staff				
	documented Client A's pulse one time on				
	1/8/13. The MAR indicated Client A was				
	in the facility ho	ome for 8 days in January			
	2013.				
	On 1/24/13 at 10	0:35 AM during an			
	interview, RN (1	registered nurse) #1			
	indicated staff sl	hould have been			
	documenting cli	ent A's blood pressure			
	and pulse as ind	icated on the MAR.			
	On 1/23/13 at 2:	35 PM during an			
	interview, Servi	ce Coordinator #1			
	indicated staff sl	hould have been			
	documenting cli	ent A's blood pressure			
	and pulse as ind	icated in her MAR.			
	Service Coordin	ator #1 indicated staff			
	should have also	been documenting client			
		ire and pulse in the daily			
	logs.				
	On 1/23/13 at 2:	45 PM, the daily logs			
		for client A for dates			
	12/1/12 to 1/2/1	3. Staff documented			
		pressure on the daily log			
		·			

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Event ID: RR5K11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/28/2013
	PROVIDER OR SUPPLIEI		1921 54	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		No further For the monitoring of pressure and pulse was			
	indicated client but was not limit eye prosthesis, a retardation and of Client A's Medical Record (MAR) of (12/1/12-12/31/(1/1/13-1/31/13) January 2013 M was given a PRI (cough medicine of 1/2/13 and 3 dinner, bedtime) 1/5/13, 1/6/13, 1 Review on 1/23, MAR for Januar client A was add Robafen-DM sy times daily (more bedtime) on 1/1/1/4/13, 1/5/13, 1 bedtime on 1/8/	t 1:30 PM a record review A's diagnoses included, ted to, depression, right arthritis, psychosis, mental cardiovascular disease. Cation Administration dated for December 2012 12) and January 2013 were reviewed. The AR indicated client A N (as needed) of Guiatuss e) 30 ML in the morning times daily (morning, on 1/3/13, 1/4/13, /7/13, and 1/8/13. 13 at 1:38 PM of the ry 2013 also indicated ministered another PRN of rup (cough medicine) 4 ming, lunch, dinner, (13, 1/2/13, 1/3/13, /6/13, 1/7/13, and at 13. 13 dis were further reviewed e:07 A.M Review of			
		al records and lab results			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G553	B. WIN			01/28/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1921 54	TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		not indicate the client had					
	a toxic level of c	ough medications in her					
	system at the tin	ne of her 1/8/13					
	hospitalization.						
		0:35 AM during an					
	interview, RN #1 indicated there was no						
	documentation on the MAR indicating the						
	reason for the PRN nor the effectiveness						
	of the PRNs given to client A between 1/1/13 to 1/8/13. RN #1 indicated staff were trained to document a reason for a						
	PRN and to mon	itor the effectiveness of					
	PRNs on the clie	ent's MAR. RN #1					
	indicated staff w	rere certified in Med Core					
	A and B (basic r	nedication					
	administration).						
	On 1/24/13 at 11	:35 AM, the facility					
	"Medication Adı	ministration Procedure"					
	policies (undated	d, received from RN #1 as					
	`	viewed. The facility					
	· · · · · · · · · · · · · · · · · · ·	ated "administration of					
	1 ^	s will be charted on the					
	indicated dosage						
	_	and effectiveness."					
	administration, a	ma offectiveness.					
	4. On 1/23/13 at	t 1:30 PM a record review					
		A's diagnoses included,					
		o, depression, right eye					
		itis, psychosis, mental					
	l ~	cardiovascular disease. A					
	comprehensive i	netabolic panel (blood					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
		15G553	B. WIN			01/28/	2013
	PROVIDER OR SUPPLIEI NORTHWEST IND			1921 54	.ddress, city, state, zip code .TH AVE W .LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	metabolic panel indicated client. Potassium level above the normal mmol/L. A review on 1/2 A's physician or indicated the client two doses of Ka to assist in decreation to assist in decreation (Potassium CL of the body) and ark lor-Con (Potassium CL of the logical continued to be order to discontinued to be order to discontinued to when the logical continued to be order to discontinued to when the logical continued to be order to discontinued to when the logical continued to be order to discontinued to when the logical continued to be order to discontinued to when the logical continued to be order to discontinued to when the logical continued to be order to discontinued to the logical continued to the logical contin	O collected on 1/03/2013 A had an elevated of 6.4 mmol/L which is all limits of 3.5-5.3 3/13 at 1:45 PM of client ders written on 1/4/13 ent had a prescription for yexalate 30gms (known easing Potassium levels in a order to discontinue ssium Chloride) and		TAG	DEFICIENCY)		DATE
	2:03PM indicate	nt A's MAR on 1/23/13 at ed the Losartan Potassium given after the order to					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/28/2013
	PROVIDER OR SUPPLIEI		1921 54	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Potassium was s	5/13). The Losartan signed by staff as 1/5/13, 1/6/13, and			
	client A's 1/8/13	4/13 at 11:00 AM of 8 lab results indicated the m level was within			
	with Pharmacist pharmacy receiv	2:05 PM, an interview #1 indicated the yed a fax with the order to Potassium CL and the ium on 1/4/13.			
	with LPN (Licer indicated she was CL and Losartar had been discontinuicated she had a fax memo of the acknowledged upon indicated she had a fax memo of the	2:35 PM, an interview nsed Practical Nurse) #1 as aware the Potassium in Potassium for client A tinued on 1/4/13. LPN #1 informed the staff with the discontinuation but apon review of client A's cinued to give both another 3 days.			
	This federal tag #IN00122535.	relates to complaint			
	9-3-6(a)				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G553	A. BUILDING B. WING		01/28/2013
NAME OF P	PROVIDER OR SUPPLIEI	3		ADDRESS, CITY, STATE, ZIP CODE	
				ATH AVE W	
	NORTHWEST IND			LLVILLE, IN 46410	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
		,			

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Event ID: RR5K11

Facility ID: 001067

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE COMPL		
THILD TEAM	or conduction	15G553		LDING		01/28/		
NAME OF			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER				1TH AVE W			
ARC OF	NORTHWEST IND	•		MERRI	LLVILLE, IN 46410			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
W0368	483.460(k)(1) DRUG ADMINIS' The system for d assure that all dri compliance with a Based on record facility failed to medications and per physician's of clients (client A) Findings include 1. On 1/23/13 a indicated client a but not limited to prosthesis, arthri retardation and of comprehensive i metabolic panel' indicated client a Potassium level above the norma mmol/L. A review on 1/2 A's physician or indicated the clie two doses of Ka to assist in decre the body) and ar Klor-Con (Potas Losartan (Losart	TRATION rug administration must ugs are administered in the physician's orders. review and interview, the administer: 1. Potassium , 2. Cough medications orders for 1 of 3 sampled). e: t 1:30 PM a record review A's diagnoses included, o, depression, right eye itis, psychosis, mental cardiovascular disease. A metabolic panel (blood) collected on 1/03/2013 A had an elevated of 6.4 mmol/L which is all limits of 3.5-5.3 3/13 at 1:45 PM of client ders written on 1/4/13 ent had a prescription for yexalate 30gms (known casing Potassium levels in a order to discontinue sium Chloride) and	WO		The policy on medication administration, documentation PRN medications, transferring orders to the MAR, and monitoring that the orders we transcribed correctly was upd on 1/31/13. To ensure future compliance this policy will be reviewed annually and revise needed.	re ated	02/19/2013	

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Event ID: RR5K11

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/28/2013	
	PROVIDER OR SUPPLIE NORTHWEST IND		1921 54	ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(MAR) dated for indicated client Potassium CL (I	Administration Record r 1/01/13 to 1/31/13 A had a prescription of Potassium Chloride) 30 osartan Potassium 100mg			
	2:02 PM indicat continued to be order to disconti Potassium CL w	ent A's MAR on 1/23/13 at end Potassium CL administered after the inue (1/4/13). The vas signed by staff as 1/5/13, 1/6/13, and			
	2:03PM indicate continued to be discontinue (1/4 Potassium was s	ent A's MAR on 1/23/13 at ed the Losartan Potassium given after the order to /13). The Losartan signed by staff as 1/5/13, 1/6/13, and			
	client A's 1/8/13	4/13 at 11:00 AM of B lab results indicated the m level was within			
	with Pharmacist	2:05 PM, an interview #1 indicated the yed a fax with the order to Potassium CL and the ium on 1/4/13.			

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Event ID: RR5K11

Facility ID: 001067

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G553	B. WIN			01/28/2013
NAME OF F	DROVIDED OD GLIDDI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>		1921 54	TH AVE W	
	NORTHWEST IND				LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
		2:35 PM, an interview				
	`	nsed Practical Nurse) #1				
		s aware the Potassium				
	CL and Losartan	Potassium for client A				
	had been discont	tinued on 1/4/13. LPN #1				
	indicated she had	d informed the staff with				
	a fax memo of th	ne discontinuation but				
	acknowledged u	pon review of client A's				
		inued to give both				
	medications for	C				
	2. On 1/23/13 a	at 1:30 PM a record				
	review of the Ma	AR for January 2013				
	included a PRN	order for Guiatuss				
	100MG/5ML sv:	rup to give 30 ML orally				
	1	needed" and a PRN order				
	1	I cough syrup to "give 10				
		fuls) orally every 4 hours				
	` *	est congestion or cough."				
	as needed for cir	est congestion of cough.				
	Review on 1/23/	13 at 1:35 PM of the				
	MAR for Januar	y 2013 indicated client A				
	was administered	d the PRN for Guiatuss				
		orning of 1/2/13 and 3				
		ning, dinner, bedtime) on				
	· · · · · · · · · · · · · · · · · · ·	/5/13, 1/6/13, 1/7/13, and				
	1/8/13.	73/13, 1/0/13, 1///13, und				
	1/0/13.					
	Review on 1/23/	13 at 1:38 PM of the				
		y 2013 indicated client A				
	was administered	-				
	Robafen-DM syn					
	1	•				
		dinner, bedtime) on				
	1/1/13, 1/2/13, 1	/3/13, 1/4/13, 1/5/13,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G553	B. WIN	G		01/28/20)13
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1921 54	TH AVE W		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	re C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1/6/13, 1/7/13, a:	nd at bedtime on 1/8/13.					
		20 PM, interview with					
		urse) #1 indicated she					
		ent A's MAR for January					
	2013 and called	the pharmacy regarding					
	staff giving both	the Robafen-DM and					
	Guiatuss for cou	gh to client A					
	simultaneously.	She indicated it would					
	not be normal pr	ocedure to give 2 PRN					
	medications for	cough but wasn't sure if it					
	was contraindica	ated for client A. RN #1					
	indicated it is no	t within facility policy for					
		uthorization to give a					
		ptoms such as chill or					
	fever were prese	•					
	On 1/24/13 at 12	2:05 PM, interview with					
	Pharmacist #1 in	idicated both					
	Robafen-DM and	d Guiatuss have the same					
	active ingredient	of Guaifenesin.					
	_	dicated client A was					
	administered up	to 2600 mg/daily of					
	_	en both PRN cough					
		bafen-DM and Guiatuss)					
	`	Il daily doses (1/3-1/7/13)					
	which is above the	-					
	maximum recom						
		nentation was presented					
		sician recommended a					
		e of Guaifenesin than the					
		aximum daily allowance.					
	1000mmended m	aminum duny anowance.					
	9-3-6(a)						
	` '		1				

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PRINTED: 03/06/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G553		LDING	00	COMPL 01/28/	ETED		
	NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
I							<u> </u>		

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Event ID: RR5K11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		15G553	B. WIN			01/28/	2013
NAME OF F	DROVADED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		1921 54	ITH AVE W		
	NORTHWEST INDI			MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0436	repair, and teach informed choices eyeglasses, hear communications a devices identified team as needed to Based on record facility failed to	furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary	W0	436	CL A had appointments with a physical therapist on and which she was una		02/19/2013
	indicated.	diffized a gait belt as			to attend due to her		
	Findings include The facility's rec	ords were reviewed on A.M The review			hospitalizations. The intention these appointments was to identify the correct adaptive equipment and/or lifting devise which would be the least restricting CL A. Current consumers do not require the assistance of a Hoyer lift, so n	es	
	involving client				additional equipment or space is required. In the event that the conditions of these or future		
	Narrative: Staff A] when she slid then complained Nurse was inforr Coordinator that complaining of c {service coordin group home staff (client A) transp for evaluation an was admitted to (oxygen) levels, tests) were all no	12, Name: [client A], were transferring [client I down to the floor and that her chest hurt. med by the Service [client A] was chest pain and that she ator} had advised the f to call 911 and have her orted to [local hospital] ad treatment. [Client A] the hospital. Vitals, O2 and labs (laboratory ormal. A CAT scan can) of the head, chest			consumers change they will be evaluated for assistive devices and alternatives that meet the needs of the client and work w in the allotted space will be obtained.	5	

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	OF CORRECTION OF CORRECTION 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/28/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION			
	and abdomen came back normal also. Consult with surgeon for spinal stenosis came back negative so [client A] is scheduled for discharge on Wednesday, 12/12/12. All medications remain as previously ordered. She [client A] came home with an order for outpatient PT/OT (physical therapy/occupational therapy). The therapist has sent her evaluation for next week. She (client A) has returned to workshop and all previous activities." Client A's record was reviewed on 1/22/13 at 12:03 P.M The review failed to indicate the PT/OT evaluation. Client A's record was reviewed on 1/22/13 at 12:03 P.M The review failed to indicate the PT/OT evaluation. "Date of incident: 12/31/12, Client: [Client A], What happened: Upon giving client [client A] a bed bath, I (direct care staff #3) noticed a scrape on her knee and a new bruise on her arm. Did incident report and notified nurse. What measures do you think could have prevented reoccurrence of this Incident/Accident?" Lead Supervisor #1 indicated: "Have adequate staff that is able to transport [client A] properly or the use of a hoyer lift (lifting device) should be implemented as soon as possible." Further review of the 12/31/12 incident						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15G553	B. WIN	G		01/28/	2013
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
4D0.0F	NODEL WATER IND	IANIA INIO TUE			ITH AVE W		
	NORTHWEST IND				_LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		taken by LPN (Licensed	+				DITE
		#1: "[Client A] was					
		sistance on the evening of					
	the 28th (12/28/	· ·					
	`	nsfer her she fought and					
	_	floor. No injury occurred					
		iff called for assistance to					
	get her (client A	A) off the floor. She					
	(client A) sustain	ned the bruise and scratch					
	while getting he	r up and into bed."					
		013, Name: [client A],					
		eived phone call from					
	1	f approximately 9:00pm					
		nt A] had slid herself					
		assistance, to the floor.					
	`	s in her behavior plan}.					
		istance to get her up since					
		ble to assist. Instructed					
		manager to send					
		over to help. Received a					
		taff stating that [client A]					
		athing and 911 had been					
		Resolve: Second staff					
	started CPR (Ca	nd continued until medics					
	1	over. [Client A] was					
		ospital] and intubated					
	-	placed). She remains on					
	life support at th	•					
	and support at th	iii iiii.					
	Client A's record	d was reviewed on					
		P.M A review of the					
		avior management plan					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G553	B. WING 01/28/2013				3
NAME OF B	DOWIDED OD SLIDDI IEE		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1921 54	TH AVE W		
	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	E	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<u> </u>	DATE
	failed to indicate						
	addressed behav	ior of sliding down to					
	floor from a seat	ed position. A 11/27/12					
	facility nursing a	assessment indicated the					
	client was, "Ver	y tired and lethargic.					
	Won't feed herse	elf or help transfer.					
	Review of a hos	pital discharge summary,					
		included a Rehab					
	· ·	Evaluation which					
	· /	A had Rehab Diagnoses					
		out were not limited to:					
		ith chest pain, and, Gait					
		General weakness." A					
		A's "Fall Risk Plan",					
	· ·	icated "[Client A] uses a					
	wheelchair and a	a gait belt to ambulate."					
	Direct care staff	#1 was interviewed on					
	1/22/13 at 5:45 I	P.M. Direct care staff #1					
	stated client A "	would not help with					
	transfers and wo	uld often slide to the					
	floor when being	g transferred due to her					
		en asked if client A had					
		elt to assist in transferring					
		taff #1 stated, "She					
	· ·	have a gait belt that I					
	know of."	nave a gait beit that I					
	KIIOW OI.						
	Direct care stoff	#2 was interviewed on					
		A.M When asked if					
		nit belt or any other					
		with transfers, direct care					
	staff #3 stated, "	No, no gait belt."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G553	B. WING		01/28/2013
NAME OF P	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE 4TH AVE W	
	NORTHWEST IND		MERRI	ILLVILLE, IN 46410	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	LPN #1 was inte 12:01 P.M LPI required two per	erviewed on 1/23/13 at N #1 stated, "[Client A] son transfers. No devices t belt) were being used."	TAG	DEFICIENCY)	DATE

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